		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011288

Facility Name: Marklund Children's Home

Address: 164 S. Prairie (Number) Bloomingdale, IL (City) 60108 (Zip Code)

County: DuPage

Telephone Number: 630 593-5479 **Fax #** 630 593-5481

IDPA ID Number: 36-2652532

Date of Initial License for Current Owners: 10/01/68

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501-(C) (3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Lisa Lipira **Telephone Number:** 630 593-5479

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Lisa Lipira

(Title) CFO & Vice President, Administration

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/11/00

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	30,956	1,460		32,416	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,956	1,460		32,416	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.68%

D. How many bed-hold days during this year were paid by Public Aid? 569 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/01/68

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 7/01/02-6/30/03 Fiscal Year: 7/01/02-6/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	228,924	14,578	17,053	260,555		260,555		260,555			1
2	Food Purchase		228,744		228,744		228,744		228,744			2
3	Housekeeping	100,044	37,128		137,172		137,172		137,172			3
4	Laundry	73,971	22,122		96,093		96,093		96,093			4
5	Heat and Other Utilities			167,089	167,089		167,089		167,089			5
6	Maintenance	63,211	30,363	69,487	163,061		163,061		163,061			6
7	Other (specify):* **Disposal Service**			29,454	29,454		29,454		29,454			7
8	**TOTAL General Services**	466,150	332,935	283,083	1,082,168		1,082,168		1,082,168			8
	B. Health Care and Programs											
9	Medical Director			32,767	32,767		32,767		32,767			9
10	Nursing and Medical Records	2,361,576	252,616	572,900	3,187,092	(52,936)	3,134,156		3,134,156			10
10a	Therapy	223,731	6,253	46,184	276,168		276,168		276,168			10a
11	Activities		28,176	3,797	31,973		31,973		31,973			11
12	Social Services	46,966			46,966		46,966		46,966			12
13	Nurse Aide Training		2,766		2,766	52,936	55,702		55,702			13
14	Program Transportation			68,492	68,492		68,492		68,492			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,632,273	289,811	724,140	3,646,224		3,646,224		3,646,224			16
	C. General Administration											
17	Administrative	80,178			80,178		80,178		80,178			17
18	Directors Fees											18
19	Professional Services			15,466	15,466		15,466		15,466			19
20	Dues, Fees, Subscriptions & Promotions			82,291	82,291		82,291		82,291			20
21	Clerical & General Office Expenses	335,403	163,025	227,472	725,900	(17,909)	707,991		707,991			21
22	Employee Benefits & Payroll Taxes			692,596	692,596		692,596		692,596			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			24,787	24,787		24,787		24,787			25
26	Insurance-Prop.Liab.Malpractice			86,475	86,475		86,475		86,475			26
27	Other (specify):* **(fundraising/promo)**			969,057	969,057		969,057	(969,057)				27
28	**TOTAL General Administration**	415,581	163,025	2,098,144	2,676,750	(17,909)	2,658,841	(969,057)	1,689,784			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,514,004	785,771	3,105,367	7,405,142	(17,909)	7,387,233	(969,057)	6,418,176			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Marklund Children's Home #0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			510,293	510,293		510,293	(281,625)	228,668			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			5,442	5,442	5,498	10,940	(10,940)				33
34	Rent-Facility & Grounds			5,498	5,498	(5,498)						34
35	Rent-Equipment & Vehicles					17,909	17,909		17,909			35
36	Other (specify):*											36
37	**TOTAL Ownership**			521,233	521,233	17,909	539,142	(292,565)	246,577			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	289,080	90,230		379,310		379,310		379,310			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			356,368	356,368		356,368		356,368			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	289,080	90,230	356,368	735,678		735,678		735,678			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,803,084	876,001	3,982,968	8,662,053		8,662,053	(1,261,622)	7,400,431			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(281,625)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(969,057)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real Estate Taxes	(10,940)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,261,622)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,261,622)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Marklund Children's Home

ID# 0011288

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Real Estate Taxes on rented site	$ (10,940)	33	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,940)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(969,057)	0	0	0	0	0	0	0	0	0	0	(969,057)	27
28	**TOTAL General Administration**	(969,057)	0	0	0	0	0	0	0	0	0	0	(969,057)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(969,057)	0	0	0	0	0	0	0	0	0	0	(969,057)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Marklund Children's Home** **# 0011288** **Report Period Beginning:** **07/01/02** **Ending:** **06/30/03**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	(281,625)	0	0	0	0	0	0	0	0	0	0	(281,625)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(10,940)	0	0	0	0	0	0	0	0	0	0	(10,940)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(292,565)	0	0	0	0	0	0	0	0	0	0	(292,565)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,261,622)	0	0	0	0	0	0	0	0	0	0	(1,261,622)	45

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	None					$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	None						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	None											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	None											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	N/A	8
1999		9
2000		10
2001		11
2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Children's Home COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0011288

CONTACT PERSON REGARDING THIS REPORT Lisa Lipira

TELEPHONE 630-593-5479 FAX #: 630-593-5481

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-14-301-031	90 Bed Facility - tax exempt	$ None	$ None
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? N/A YES N/A NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	206,930	1968	$ 31,500	1
2					2
3	TOTALS	206,930		$ 31,500	3

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1968	1953	$ 68,500	$	33	$	$	$ 68,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Pavillon land impr			1989	6,485	324	20	324		4,702	9
10	Landscaping land impr			1990	1,080		10			1,080	10
11	Asphalt Paving Land impr			1991	7,112		5			7,112	11
12	Asphalt Seal & Strip Parking Lot land impr			1994	14,893		5			14,893	12
13	Asphalt Land impr			1996	800		5			800	13
14	Seal & Repair Driveway Land impr			1998	600	120	5	120		540	14
15	Parking Lot Concrete Asphalt land impr			1999	300	60	5	60		210	15
16	Parking Lot Concrete Asphalt land impr			1999	32,199	6,440	5	6,440		22,539	16
17	Removal of ramp & installation of new land impr			1999	2,100	420	5	420		1,470	17
18	Parking Lot Concrete Asphalt land impr			2000	300	60	5	60		210	18
19	Resurface Playground land impr			2000	7,750	1,550	5	1,550		3,875	19
20	Sealcoat & Striping of Parking lot land impr			2000	3,187	637	5	637		1,593	20
21	Safety Surfacing of Playground			2000	6,094	1,219	5	1,219		3,047	21
22	Landscaping of Playground land impr			2000	3,325	665	5	665		1,663	22
23	Improvements prior to 1996 fully depreciated				208,807		v			208,807	23
24	Building Construction Pod II			1973	615,786	17,009	40	17,009		471,192	24
25	Oxygen Work			1974	74,064	2,047	40	2,047		54,610	25
26	Oxygen Work			1975	5,000	135	40	135		3,581	26
27	Oxygen Work			1976	7,535	188	40	188		5,226	27
28	New Roof			1986	81,000	4,050	20	4,050		70,875	28
29	Lobby Addition			1984	108,605	5,030	25	5,030		85,969	29
30	Parents Room			1987	42,000	2,100	20	2,100		32,550	30
31	POD general renovations floors/walls			1992	22,173	250	10	250		22,173	31
32	Fire Alarm			1993	850	43	10	43		850	32
33	Oxygen System			1993	13,429	671	10	671		13,429	33
34	Carpeting			1995	2,984	298	10	298		2,536	34
35	Water Heaters			1995	8,916	892	10	892		7,579	35
36				1995	644	64		64		483	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39	Window shades dining room	2000	605	121	5	121		424	39
40	Lobby walls	2000	57	11	5	11		40	40
41	Awnings rear entrance	2000	2,023	405	5	405		1,416	41
42	lower level classroom renovations	2000	183	37	5	37		128	42
43	awning for O2 protection	2000	3,477	695	5	695		2,434	43
44	Lobby walls	2000	4,997	999	5	999		3,498	44
45	HVAC-dining room	2000	610	122	5	122		427	45
46	Dining room walls & wall coverings	2000	2,060	412	5	412		1,442	46
47	HVAC coil dining room	2000	1,590	318	5	318		1,113	47
48	fire doors lower level	2000	564	56	5	56		197	48
49	carpet flooring lower level	1999	5,855	1,171	5	1,171		4,099	49
50	lower level classroom renovation	1999	1,346	269	5	269		942	50
51	replacement windows	1999	538	108	5	108		377	51
52	Construction, engineering, architect, inspection	1999	49,390	4,939	10	4,939		17,287	52
53	fire sprinkler system	1999	72,843	2,914	25	2,914		10,198	53
54	interior design, handrails, corner pieces	1999	29,873	1,992	15	1,992		6,970	54
55	Demolition old lower level	1999	26,641	2,664	10	2,664		9,324	55
56	Chair rails	1999	8,160	1,632	5	1,632		5,712	56
57	Wall Carpet	1998	4,887	977	5	977		4,398	57
58	Painting lower level	1999	19,835	3,967	5	3,967		13,885	58
59	lower level construction walls	1999	101,713	10,171	10	10,171		35,600	59
60	cabinets	1999	46,002	3,067	15	3,067		10,734	60
61	Reg. & auto doors	1999	18,259	1,826	10	1,826		6,391	61
62	Equip relocation	1999	2,495	499	5	499		1,747	62
63	Electrical work lower level	1999	29,697	2,970	10	2,970		10,394	63
64	windows/shutters	1999	15,529	1,553	10	1,553		6,212	64
65	Floor/carpeting	1999	46,503	9,301	5	9,301		32,552	65
66	Signage Interior/Exterior	1999	3,899	390	10	390		1,365	66
67	Plumbing lower level	1999	21,177	1,059	20	1,059		3,706	67
68	ECU Awnings	1999	3,994	266	15	266		932	68
69	Paneling	1999	7,309	1,462	5	1,462		5,116	69
70	TOTAL (lines 4 thru 69)		$ 1,878,629	$ 100,645		$ 100,645	$	$ 1,311,154	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,878,629	$ 100,645		$ 100,645	$	$ 1,311,154	1
2	Security System,Elevator	1999	11,010	734	15	734		2,569	2
3	New door hardware	1999	197	20	10	20		69	3
4	Fire alarm system upper level	1999	12,491	500	25	500		1,749	4
5	Water Heater	2001	767	153	5	153		384	5
6	Air Curtain	2001	764	153	5	153		382	6
7	Replacement Parts - Boiler	2001	5,290	1,058	5	1,058		2,645	7
8	Compressor Pump	2001	1,599	320	5	320		800	8
9	Security Door	2001	2,427	485	5	485		1,213	9
10	New Flooring	2000	2,955	591	5	591		2,068	10
11	Roof Repair	1999	8,800	1,760	5	1,760		7,920	11
12	New compressor	1999	2,580	172	15	172		774	12
13	Awnings	1999	2,520	504	5	504		2,268	13
14	Boiler	1998	2,675	535	5	535		2,408	14
15	Plexiglass-reception area	2002	3,100	620	5	620		930	15
16	Stairwell Door replacements	2001	1,165	233	5	233		350	16
17	New Radiator for generator	2001	3,002	600	5	600		901	17
18	Sliding door repair	2002	4,179	418	5	418		418	18
19	Carpeting	2002	1,690	169	5	169		169	19
20	Awning	2002	2,694	269	5	269		269	20
21	Concrete Pads for Oxygen, Chiller, and Garbage	2002	15,571	1,557	5	1,557		1,557	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,964,105	$ 111,496		$ 111,496	$	$ 1,340,997	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 516,288	$ 87,892	$ 87,892	$		$ 415,237	71
72	Current Year Purchases	97,010	6,246	6,246			6,246	72
73	Fully Depreciated Assets	480,846					480,846	73
74								74
75	TOTALS	$ 1,094,143	$ 94,138	$ 94,138	$		$ 902,329	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2000 International Bus	2000	$ 62,500	$ 12,500	$ 12,500	$	5	$ 43,750	76
77	Maintenance Use	2000 Isuzu Truck	2000	31,007	6,201	6,201		5	21,704	77
78	General Use	2000 Chrysler	2000	26,000	4,333	4,333		3	26,000	78
79										79
80	TOTALS			$ 119,507	$ 23,034	$ 23,034	$		$ 91,454	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,209,255	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 228,668	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 228,668	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,334,780	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land Improvements (1990-2001)	$ 185,430	$ 18,543	$ 37,680	86
87	Build & Build Impr. (1990-2002)	1,000,000	146,961	553,230	87
88	Equipment (1990-2003)	500,000	91,802	228,272	88
89	Vehicles (1990-2002)	243,190	24,319	135,920	89
90					90
91	TOTALS	$ 1,928,620	$ 281,625	$ 955,102	91

G. Construction-in-Progress

	Description	Cost	
92	Design Fees	$ 33,162	92
93			93
94			94
95		$ 33,162	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 17,909 Description: Office equipment/machinery
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	87

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	44

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		494	2,272		2,766
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)	9,453	43,483		52,936
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 9,947	$ 45,755	$	$ 55,702
10	SUM OF line 9, col. 1 and 2	(e)	$ 55,702			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
TOTAL TRAINED	28

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	line 39, Col. 8	13140	289,080			90,230	13,140	379,310	12
13	Other (specify):									13
14	TOTAL			$ 289,080		$	$ 90,230	13,140	$ 379,310	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,467,511	$ 2,467,511	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 91,502)	2,151,348	2,151,348	3
4	Supply Inventory (priced at Cost)	59,900	59,900	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	164,201	164,201	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Client Related Accounts	546,114	546,114	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,389,074	$ 5,389,074	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,217,448	5,217,448	13
14	Buildings, at Historical Cost	12,644,044	12,644,044	14
15	Leasehold Improvements, at Historical Cost	4,547	4,547	15
16	Equipment, at Historical Cost	4,062,905	4,062,905	16
17	Accumulated Depreciation (book methods)	(7,143,276)	(7,143,276)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	7,869,638	7,869,638	21
22	Other Long-Term Assets (specify):	1,149,049	1,149,049	22
23	Other(specify): Construction in Progress	5,690,361	5,690,361	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 29,494,716	$ 29,494,716	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 34,883,790	$ 34,883,790	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 531,968	$ 531,968	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	217,708	217,708	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,655	16,655	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Misc. Other Accrued	3,205,759	3,205,759	36
37	Client Related Liability	546,114	546,114	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,518,204	$ 4,518,204	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,518,204	$ 4,518,204	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 30,365,586	$ 30,365,586	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 34,883,790	$ 34,883,790	48

***(See instructions.)**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 25,923,643	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 25,923,643	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,289,743)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	5,931,457	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Remaining Consolidated Inc/(Loss)**	(375,689)	15
16	Other (describe) **Change in Unrealized Gains/(Losses)**	175,918	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 4,441,943	17
	B. Transfers (Itemize):		
18	**Transfer out of Restricted Funds into Operations-Expenses**	(344,344)	18
19	**Transfer out of Restricted Funds into Operations-Capital**	(9,360,436)	19
20	**Transfer into Operations from Restricted -Expenses**	344,344	20
21	**Transfer into Operations from Restricted -Capital**	9,360,436	21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 30,365,586	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,018,274	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,018,274	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	70,237	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	13,839	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 84,075	23
	D. Non-Operating Revenue		
24	Contributions	7,980	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,980	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine/Cafeteria	358	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 358	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,110,688	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,082,168	31
32	Health Care	3,646,224	32
33	General Administration	1,689,784	33
	B. Capital Expense		
34	Ownership	246,577	34
	C. Ancillary Expense		
35	Special Cost Centers	379,310	35
36	Provider Participation Fee	356,368	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,400,431	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,289,743)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,289,743)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,080	$ 65,229	$ 31.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,104	25,372	581,059	22.90	3
4	Licensed Practical Nurses	5,459	5,746	170,394	29.65	4
5	Nurse Aides & Orderlies	117,238	123,408	1,544,894	12.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	2,964	3,120	46,966	15.05	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	42,338	20.35	13
14	Head Cook	5,928	6,240	78,000	12.50	14
15	Cook Helpers/Assistants	7,859	8,273	86,770	10.49	15
16	Dishwashers	1,976	2,080	21,816	10.49	16
17	Maintenance Workers	4,778	5,029	63,211	12.57	17
18	Housekeepers	11,856	12,480	100,044	8.02	18
19	Laundry	8,760	9,221	73,971	8.02	19
20	Administrator	3,034	3,193	80,178	25.11	20
21	Assistant Administrator					21
22	Other Administrative	15,090	15,885	335,403	21.11	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,562	10,065	156,724	15.57	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	8,604	9,056	67,007	7.40	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) RN-Excep Care	12,483	13,140	289,080	22.00	33
34	TOTAL (lines 1 - 33)	243,647	256,468	$ 3,803,084 *	$ 14.83	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	330	$ 16,355	1	35
36	Medical Director	Monthly	32,767	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	825	46,184	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	37	3,151	10	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,192	$ 98,457		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	18,600	569,749	10	52
53	TOTAL (lines 50 - 52)	18,600	$ 569,749		53

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terri Bowen-Weyrich	Admin Support		$ 80,178
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,178

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KPMG	Audit Fees	$ 15,466
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 15,466

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,826
Unemployment Compensation Insurance	13,651
FICA Taxes	290,936
Employee Health Insurance	200,168
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	99,781
Dental	17,040
Life Insurance/Disability	1,194
TOTAL (agree to Schedule V, line 22, col.8)	$ 692,596

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	71,647
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA Dues	4,212
Misc. Licesnes and Permits	690
Misc. Dues and Subscriptions	5,741
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,291

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assoc. $ 4,212

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 71,998 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 356,368
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes (NDSEC Rent) For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ N/A Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 15%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Marklund Children's Home
IDPH Facility ID Number #0011288
Fiscal Year 2003
Schedule V. Cost Center Expenses

Line #10 & Line #13

Reclassification:

Wages for the in-house trainer for our Nurses Aide Training Program: $52,936

Note: This is also reflected on Schedule XIII. Expenses relating to Nurse Aide Training Program

Line #21

Reclassification:

Rental Expenses for Office Equipment (Copy Machines) $17,909

Note: This is also reflected on Schedule XII. Rental Costs on Equipment

Line #33 & #34

Reclassification:

Real Estate Taxes reclassed from Rent-Facility to Real Estate Taxes on a rented site

Note: All Real Estate Taxes are ultimately adjusted out of the cost report when filed $5,498

Marklund Children's Home
IDPH Facility ID Number #0011288
Fiscal Year 2003
Schedule VI. Adjustment Detail

Line # 33

Adjustment: Non-Allowable

Real Estate Taxes:	$10,940

Marklund Children's Home
IDPH Facility ID Number #0011288
Fiscal Year 2003
Schedule XX. General Information

Line #14

There is minimal space, (one classroom), that is rented to NDSEC to provide schooling to some of our clients. There are no costs associated with this. NDSEC supplies their own teachers and supplies, etc. We generate minimal income for the rental of this room, $13,839, (reflected on Schedule XVII., Income Statement, Line #16).

Marklund Children's Home
IDPH Fadility ID Number #0011288
Fiscal Year 2003
Schedule XII. Rental Costs
Listing of Moveable Equipment

Description	Quantity
Minolta Fax 2600	2
Minolta D1550	1
Lanier 6720 AG	1
Medical Equipment - Pulse Oxymeters Oxygen Concentrators Oxygen Compressors	Various